

Andrew H Kim DDS
Aesthetic Dental Group

1655 E Thousand Oaks Blvd Ste 204 Thousand Oaks CA 91362

PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ MI _____ TODAY'S DATE _____
SEX: M F STATUS: Minor Single Married Divorced Widowed BIRTHDATE: _____ AGE: _____ Soc. Sec. # _____
HOME NO _____ CELL NO _____ EMAIL _____
If Patient is a Minor, give Parent's or Guardian's Name : _____
Who May We Thank for Referring You to our Office? _____
Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____
RELATION TO PATIENT _____ SEX: M F STATUS: Single Married Divorced Widowed
SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____
RESIDENCE Street _____ Apt # _____
City _____ State _____ Zip _____
MAILING ADDRESS Street _____ Apt # _____
City _____ State _____ Zip _____
HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ CELL PHONE _____
WORK PHONE _____ EMAIL _____
PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ Apt # _____
City _____ State _____ Zip _____ How Long _____
EMPLOYER _____ OCCUPATION _____
NO. YEARS EMPLOYED _____

RESPONSIBLE PARTY'S SPOUSE

NAME _____
LAST FIRST MIDDLE
EMPLOYER _____
OCCUPATION _____ ()
NO. YEARS EMPLOYED
SOC. SEC. # _____ BIRTHDATE ____/____/____
HOME PH. _____ CELL PH. _____
WORK PH. _____ E-MAIL _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____ RELATIONSHIP _____
ADDRESS _____
CITY _____ STATE _____
HOME PH. _____ CELL PH. _____
WORK PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____
Insurance Co. _____ PH # _____
Insurance Co. Address _____
Insured's Employer _____
Insured's Soc. Sec. # _____ Group # _____
Local # _____

OTHER DENTAL INSURANCE INFORMATION (Secondary Carrier)

Insured's Name _____
Insurance Co. _____ PH # _____
Insurance Co. Address _____
Insured's Employer _____
Insured's Soc. Sec. # _____ Group # _____
Local # _____

I assure the information on this page and the dental/medical history are correct to the best of my knowledge. I authorize Aesthetic Dental Group, Andrew H Kim DDS, to utilize the information provided in conjunction with information collected utilizing diagnostic tools, not limited to radiographs, photographs, and diagnostic instruments, to diagnose, treatment plan, administer medications and treat oral disease necessary for proper dental care.

I authorize Aesthetic Dental Group, Andrew H Kim DDS, to release any information pertaining to but not limited to dental/medical history, the records of examination, diagnosis, and treatment rendered to my self or my dependents during the period of such dental care, to third party payers and/or health professionals. I authorize and request my insurance company to pay directly to Aesthetic Dental Group, Andrew H Kim DDS, insurance benefits otherwise payable to me.

I understand that I am financially responsible for all charges whether or not paid by insurance or third party payers. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand all fees are due at the time services are rendered, unless other financial arrangements have been previously made. I understand that dental insurance carriers may or may not pay less than the actual bill for services. I agree to pay interest (2% per month) on any accrued indebtedness beyond 30 days, together with such collection costs and reasonable attorney fees as may be required to effect collection of this obligation.

Aesthetic Dental Group, Andrew H Kim DDS, reserves rights to refer or decline services at our discretion.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____